

Debate

On lying and deceiving

David Bakhurst Queen's University at Kingston, Ontario, Canada

Author's abstract

This article challenges Jennifer Jackson's recent defence of doctors' rights to deceive patients (1). Jackson maintains there is a general moral difference between lying and intentional deception: while doctors have a prima facie duty not to lie, there is no such obligation to avoid deception. This paper argues 1) that an examination of cases shows that lying and deception are often morally equivalent, and 2) that Jackson's position is premised on a species of moral functionalism that misconstrues the nature of moral obligation. Against Jackson, it is argued that both lying and intentional deception are wrong where they infringe a patient's right to autonomy or his/her right to be treated with dignity. These rights represent 'deontological constraints' on action, defining what we must not do whatever the functional value of the consequences. Medical ethics must recognise such constraints if it is to contribute to the moral integrity of medical practice.

When, if ever, is it permissible for doctors to mislead patients? That is, when is it legitimate for a doctor to act so that a patient acquires, or continues to hold, false beliefs about his or her condition and its treatment? In *Telling the truth* (1), Jennifer Jackson maintains that the answer depends on *the way* the doctor misleads the patient. She argues that there is a general moral difference between (a) lying and (b) deliberately or intentionally deceiving, and that while everyone is bound by a *prima facie* duty not to lie, there is no such obligation to avoid intentional deception. Jackson thus concludes that while doctors must not lie, they may deliberately deceive if they believe this to be in the patient's interest, and if the deception does not involve a breach of trust. Jackson is confident that deception need not breach trust.

I believe Jackson's account is flawed, both in its theoretical content and in its implications for medical practice. Her claim that there is a general, morally relevant difference between lying and intentional deception is false. Moreover, in making this claim she invokes a theory of moral reasons that, though

alluring, is misconceived. The resulting position trivialises the moral significance of deception, and encourages a form of medical paternalism, where doctors may, 'for the patient's well-being', control the 'dosage' of information the patient receives, so long as they do not actually lie. This seems a position designed to satisfy no one: while advocates of paternalist medicine will resist the restriction against lying (if paternalism is justified why be weak-kneed about it?), its opponents will charge Jackson with supporting practices that, however well intentioned, are ultimately degrading to patients. In what follows, I explore the theoretical deficiencies in Jackson's account in an effort to establish a more satisfying analysis of the value of truthfulness in medical practice.

Is there a general moral difference between lying and deceiving?

According to Jackson, I lie to you if, knowing *p* is false, I inform you that *p* is true in order to cause you to believe *p*. In contrast, I deliberately deceive you if, knowing *p* is false, I intentionally act in a way that leads you to believe *p*. This way of drawing the distinction, however, invites confusion. Since informing you that *p* is a way of leading you to believe *p*, lying appears to be a species of intentional deception. How, then, can we ask whether lying is better or worse than deliberately deceiving? Jackson tries to deny that lying is a species of deliberate deception because the latter requires that the deceiver be successful in causing a false belief, where the former does not (2). Her point, however, shows only that (strictly speaking) lying is a form of deliberate deception just where it is *successful*, otherwise lying is merely *attempting* to deceive. But conceding this makes the question of whether there is a moral difference between lying and deliberate deception no less odd, because lying (successfully) is still a way of deceiving.

Let us therefore modify Jackson's definition of deception thus: I deliberately deceive you if I intentionally act to cause you to believe some falsehood *p*, without actually lying to you (ie, without asserting that *p* is true). The central moral question about the relation of lying and deceiving is therefore this: Is there a general moral difference between misleading people

Key words

Lying; deception; functionalism; obligation; rights; deontological constraint.

by telling lies and misleading them by some other means?

ARGUMENTS FROM EXAMPLE

If we approach this question by examining examples, the answer appears to be a clear 'No'. Of course, trivial instances of deception abound (for example, wearing a wig, laughing politely at bad jokes, etc), but many lies are also morally insignificant (for example, 'I really enjoyed your lecture, Professor Bakhurst!'; 'This is delicious', etc). And equally, in many serious cases there is simply no moral difference between lying and deceiving. For example, I am just as much at fault if I mislead patients about my expertise by displaying fake certificates in my office as if I tell outright lies about my qualifications. And to trick someone into agreeing to an unnecessary course of expensive private treatment is just as wrong whether this is achieved by lying or deception. Here lying and deception come morally to the same thing.

This is equally true in many cases where the reasons for misleading patients are benevolent. If I believe that a patient should not be told that he is terminally ill, is it really worse for me to tell him that he will get better, than to hint at his recovery by discussing his future holiday plans? Indeed, those who endorse medical paternalism might argue that, when a doctor is convinced the patient must not know the truth, it is often *better* to lie than to mislead by suggestion. This is not just because lying is often more effective, it is also more courageous. By lying, doctors clearly commit themselves to a paternalistic strategy and make it easier for others to hold them accountable. However, whatever one thinks of this suggestion, there is so far no reason to suppose that it is always morally preferable to deceive than to lie.

Consider a case raised by Jackson herself. She describes a locum treating a patient who has not been told she has terminal cancer. The locum decides that the patient's own doctor, and not himself, should tell the patient of her condition. What is the locum to do, however, if the patient confronts him with the question: 'Have I got cancer?' Jackson counsels that he deceive the patient without actually lying, and proposes he do this by saying: 'I don't know your case fully ... I have not talked about your case in depth with your specialist' (3).

In my view, this example only illustrates how difficult it is to drive a moral wedge between lying and deliberate deception. Note that it is not at issue whether the locum should tell the patient the outright lie that she does not have cancer. Such a thing would be monstrous, though it would be just as bad if he led her to the same belief by a strategy of deception. The question is only what means he should use to *stall* until her regular doctor returns. Nothing about the example suggests that it would be worse for the locum to tell a bold-faced lie, than to deceive the patient some other way. Indeed, the words Jackson offers the locum *are* lies: he certainly knows the case well enough to answer

the patient's question. Furthermore, as we think through the reality of the locum's predicament, it becomes obvious that to sustain a strategy of deliberate deception he may eventually *have to* lie. Patients know how to put doctors on the spot, and they also know when doctors are trying to evade the issue. Does it not occur to Jackson that the patient might wonder why she is being treated by a doctor who claims not to know what disease she is suffering from? The suggestion that he should deceive without lying is thus as worthless in practice as it is dubious in theory.

ARGUMENTS FROM THE NATURE OF MORAL OBLIGATION: JACKSON'S FUNCTIONALISM

Jackson's confidence that there is a general moral difference between lying and deliberate deception is premised on a particular account of the nature of moral obligation (2). Jackson offers a consequentialist justification of our duty not to tell lies which appeals to the role of truthfulness in preserving social cohesion. In a society that did not observe a prohibition against lying, she argues, the institution of trust would be undermined with disastrous consequences. This is consequentialism with its sights set low: the consequence moral rules serve to realise is not the best possible state of affairs, but simply one in which society survives (3). Thus, Jackson's position might be called a form of 'functionalism', first because moral rules are justified by their function, and second because their function is precisely to ensure the functioning of society.

Jackson proceeds to argue that though functionalist reasons support a rule against lying, such considerations do not apply in the case of intentional deception, which she maintains, often serves to sustain our communities, rather than to undermine them. We laugh at each other's inept witticisms, try to make ourselves look younger or thinner than we are, we feign pleasure at receiving unwanted gifts, and so on. Far from threatening community, such deceptions are, Jackson suggests, essential to maintaining social cohesion. There is therefore no general moral obligation to refrain from intentional deception.

I have three objections to Jackson's position: (i) Even if we concede that the moral rule against lying is justified by the need to preserve trust, it is false that lying threatens the institution of trust in a way that deliberate deception does not. As Jackson admits, many cases of intentional deception involve breaches of trust. If a doctor deliberately deceives her patient into agreeing to some risky cosmetic surgery, she should not be surprised if, after the operation, the disappointed patient insists that she will never trust her again. Furthermore, lying plays a similar role in preserving cordial social relations as deliberate deception. This is the role of many 'white' lies: we compliment people on their mediocre cooking, we praise our colleagues' weak first drafts, and so on. Thus, if Jackson is right that the issue turns on the necessity of preserving trust, she is wrong that there is

a general moral difference between lying and deliberately deceiving.

Ironically, this conclusion seems particularly clear in the case of the relation between doctor and patient. The usual imbalance of power and expertise between doctor and patient makes it especially important that the former merits the latter's trust. If the patient makes her trust conditional upon the doctor providing all the relevant information about her condition, then trust is as easily compromised by a strategy of lying or deception. It is revealing that Jackson illustrates her position with a case involving a *locum*, for locum and temporary patient do not have the same relation of trust as patient and regular doctor. It is precisely for this reason that we are prepared to tolerate the locum's reluctance to tell the patient the truth, and not because deception as such does not endanger trust. If the patient's regular doctor avoided her questions, he would clearly be guilty of a breach of trust (among other things), whether he lied to her or otherwise deceived her.

(ii) If someone explains the value of a moral rule in terms of its function to prevent some consequence, they must express a view about the status of that rule in particular cases where breaking it would *not* bring about that consequence. Let us call this 'the exception problem'. Jackson's response is that if departing from a rule in a particular case will 'still allow us to get by [ie will not undermine social cohesion] ... then the departures *can* be allowed' (3). This invites someone to make a special case for doctors' rights to tell benevolent lies to their patients on the ground that, when justified, such deceit does not in fact breach trust. Obviously, Jackson cannot mean that the social institution of trust *as such* would be threatened if we allowed that doctors should sometimes (or even often) lie to patients. What is at issue is only whether patients' trust in the medical profession would be undermined. And it could very well be argued that this need not be so. In a society where medical paternalism is accepted as normal practice, patients may expect their doctors to lie to them in appropriate circumstances. Indeed, in such a society the relation of trust between doctor and patient may be premised on the assumption that the doctor will protect the patient not only from illness, but also from the cruel truth. This shows that Jackson's arguments lack a critical edge precisely where one is most needed: they have no force whatever against a medical culture where paternalism is so widespread that patients expect it, tolerate it, and even welcome it.

(iii) The fatal flaw in Jackson's functionalist consequentialism is revealed, however, if we explore the 'exception problem' further. Suppose we hold that the reason the police have a duty to obey the law is that, were they to break it in the prosecution of crime, the legal system would be undermined with terrible consequences for society. Suppose now that, in a particular case, the police believe that the consequences will be disastrous if they do *not* secretly break the law. They argue that confidence in the legal

system will actually be lost if they do not secure a conviction, and they can do this only by framing an innocent person. What reason can the functionalist give why the police should nevertheless obey the law? A popular option is to argue that the value of breaking the law is outweighed by the possible consequences of being found out. If people were to learn that the police had secured false convictions, it is reasoned, then that would diminish confidence in the legal system all the more. This move, however, only reveals how curious is the functionalist portrayal of moral reasons. The *moral* reason why the police should not frame people, whatever the social utility of so doing, is because these people are *innocent*, and not because of the unhappy consequences of the truth coming out. The latter is surely not a moral reason at all! By the same token, the reason my doctor should not lie to me (or otherwise deceive me) is not because of the possible consequences of breaking some social rule, but because something is wrong with lying or deception *as such*. As a patient, I want my doctor to tell me the truth out of respect for me, and not because of the social usefulness of truth-telling. A functionalist approach thus offers the wrong kind of reasons why we should be moral (4).

The kind of functionalist views Jackson favours are presently popular in medical ethics. Philosophers are anxious that the medical profession take ethical argumentation seriously, and they rightly suspect that practitioners habitually involved in the dramas of real medical decisions may be sceptical of seemingly abstract philosophical debates about 'duty', 'obligation' and other deontological notions. Thus the philosopher feels bound to provide an explanation of the source of our moral obligations, and is drawn to theories that his or her medical colleagues will find comparatively unproblematic. A functionalist account is therefore attractive, since functionalist explanations abound in the biological sciences. However, if I am right, functionalist explanations of moral obligation are fundamentally misguided. Thus, however persuasive they seem, they must be rejected as a foundation for medical ethics.

A sketch of an alternative

What, then, is wrong with doctors lying or deceiving their patients? Except in very special circumstances, to mislead patients is to deny them due respect; it implies they are incapable of understanding, accepting and controlling their situation. Lying or deception is therefore an abuse of power that infringes the patient's right to self-determination and self-knowledge. It is, in short, an affront to the patient's dignity and autonomy. Moreover, the practice of deceiving patients contributes to the cult of expertise surrounding the medical profession, and to a view of doctors not as providing a service, but as guardians of a special wisdom, which they may determine when, and to whom, to divulge.

I believe that an approach based on the notions of dignity and autonomy best conforms to our intuitions

about those special circumstances in which it is sometimes legitimate for doctors to mislead patients. Jackson follows Roger Higgs's view that deception is permissible only 'at either end of the scale of importance'; that is, in trivial cases, such as where a doctor might politely lie about being inconvenienced, or in extreme crises (5). I find this position unsatisfactory for two reasons.

First, I believe there are cases which are neither trivial nor critical where we are prepared to tolerate benevolent deception from doctors in order to help patients through some temporary distress, so long as the truth is made known as soon as possible. For example, if a badly injured patient in casualty anxiously asks: 'Will I make that job interview on Monday?', it is hard to blame the doctor if she answers: 'Maybe, hang on in there', because this is not a good time to break the news that the chances are nil. Deception might also be permitted in certain cases where a patient's full knowledge of his or her condition might seriously inhibit recovery; for example, in cases where patients (children perhaps) will be unduly or irrationally frightened by an accurate description of their predicament. In both cases, however, such well-intentioned help becomes illegitimate as soon as it threatens the patient's dignity or autonomy.

Second, and more importantly, I am very suspicious of the claim that deception is more likely to be legitimate in a crisis. Surely, it is precisely in such cases that doctors are under a special obligation to be truthful. This is particularly so in terminal cases where a strategy of benevolent deception may deny patients the opportunity, albeit the tragic opportunity, to come to terms with their own mortality, to reflect on the character of their life in the light of their imminent death, and to take proper leave of friends and family.

The position I have outlined discusses the morality of deception in terms of the right to autonomy, and the right to be treated with dignity. Such rights may be seen as 'deontological constraints' upon our actions, specifying things we should not do regardless of the consequences. As such, the kinds of obligations these constraints place upon us cannot be explained within the kind of consequentialist framework Jackson finds attractive. Indeed, it may be impossible to justify such constraints in a way that does not appeal to some

further moral concept which might itself be challenged. There is perhaps no story we can tell in non-moral terms (for example, in terms of consequences, functions, or the demands of rationality and consistency), that will silence the moral sceptic. What can be said to someone who asks why he should treat other people with dignity, except perhaps that to do otherwise is to fail to recognise their humanity? And if the next question is: 'Why should I care about their humanity?', there simply is nothing to say. But this does not show that a belief in the value of human dignity is unjustified; it is just that from the perspective of someone who genuinely cannot see why he should care about the humanity of others, nothing *could* count as a reason to respect human dignity. Thus, if someone does not recognise the value of such deontological constraints, no argument will bring him round. However, recognise these constraints we must, not only if we are to appreciate the true wrongness of lying or deception in medical contexts, but also if the discipline of medical ethics is to make a genuine contribution to the moral integrity of medical practice (6).

David Bakhurst is an Assistant Professor in the Philosophy Department, Queen's University at Kingston, Ontario, Canada.

References and notes

- (1) Jackson J. Telling the truth. *Journal of medical ethics* 1991; 17: 5-9.
- (2) See reference (1): 6.
- (3) See reference (1): 8.
- (4) In his *Fundamentals of ethics*, Oxford: Oxford University Press, 1983, ch 4, John Finnis develops a similar point into an attack on the entire species of consequentialist positions.
- (5) Higgs R. On telling patients the truth. In: Lockwood M, ed. *Moral dilemmas in modern medicine*. Oxford: Oxford University Press, 1985.
- (6) A version of this paper was read in reply to Jennifer Jackson at a Queen's University philosophy colloquium in October 1990. I am indebted to Ms Jackson and to my colleagues at Queen's for their responses then. I am also grateful to Alistair MacLeod for his comments on the manuscript.

continued from page 62

raising discipline ('How would you like it if someone kept the truth from you?') or as a matter of applying rules and principles to difficult cases (8).

Robin Downie is Professor of Moral Philosophy at the University of Glasgow.

References

- (1) Gillon R. Philosophy and the teaching of health care ethics. *Journal of medical ethics* 1991; 17: 171-172, 198.
- (2) Smith A. *The theory of moral sentiments*. Oxford: Oxford University Press, 1976: VII, iv, 17.
- (3) See reference (2): VII, iv, 34.
- (4) See reference (2): VII, iv, 33.
- (5) Smith A. *Lectures on rhetoric and belles lettres*. Oxford: Oxford University Press, 1983: 149.
- (6) Smith A. *Essays on philosophical subjects*. Oxford: Oxford University Press, 1980: 119.
- (7) Moore G E. *Principia ethica*. Cambridge: Cambridge University Press, 1903: 4-5.
- (8) Elliott C. Solving the doctor's dilemma? *New scientist* 1992 Jan 11: 42-44.